SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM (EIP)
COBRA NOTICE OF ELECTION

C
SEE INSTRUCTIONS IF COMPLETING BY HAND USE BLACK INK

ELIG.

Select ONE:
☐ Left Employment, RIF - Eligible for 18 Months *(includes employee, spouse and dependents)*
☐ Disabled, Provide Copy of Social Security Award Letter - Eligible for 29 Months
☐ Divorced ☐ Separated ☐ Dependent Child Eligibility Ended - Eligible for 36 Months

Sponsoring Employee/Retiree Social Security Number

Date of Occurrence:
Month Select
Date Select
Year Select

Verification of Eligibility ***(required of subscribers from entities other than state agencies and school districts)***
Benefits Administrator Signature _____ **Employer ID** _____

ACTION

Select ONE of the Following:
☐ New Subscriber ☐ Termination
☐ Address Change
☐ Change *(Specify)* _____

Date of Occurrence _____ SSN Change - Incorrect # _____
(Attach Copy of Social Security Card)
Name Change - Prior Name _____

EIP USE ONLY
Employer ID _____
Effective Date _____
Group ID# _____

ENROLLEE INFO

1. Social Security Number	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM/DD/YYYY
_____-_____-_____					

7. Sex	8. Marital Status	9. Home Phone #	10. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	( )	

11. Mailing Address	12. Apt.	13. City	14. State	15. Zip Code	16. County Code
					Select

COVERAGE

It is your responsibility to select the appropriate insurance coverage. See the benefits options before making your selection. Select one health plan and dental plan(s). To refuse coverage, mark "REFUSE."

17. HEALTH PLAN *(Refuse or select one plan and one category)*

PLAN
☐Standard ☐HMO_____ *Name of HMO*
☐Savings (Non-Medicare)
☐Refuse All Above Health Plans

CATEGORY
☐Enrollee ☐Enrollee/Child(ren)
☐Enrollee/Spouse ☐Family
☐Child Only Through Age 18

18. STATE DENTAL PLAN *(Select One)*
☐Enrollee/Spouse
☐Refuse ☐Enrollee/Child(ren)
☐Enrollee ☐Family
☐Child Only Through Age 18

19. DENTAL PLUS *(Select One)*
☐Yes ☐Refuse
(You must be enrolled in the State Dental Plan to elect Dental Plus. If no election is indicated for Dental Plus, you will not be enrolled for this coverage.)

MEDICARE AND OTHER COVERAGE

LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR PART B OF MEDICARE.

20. NAME	MEDICARE#	ELIGIBLE DUE TO	EFFECTIVE DATE PART A MM/DD/YYYY	EFFECTIVE DATE PART B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

Do you or any of your dependent(s) have other health coverage? ☐YES ☐NO **Does this coverage include pharmacy benefits? ☐YES ☐NO**

If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing conditions, if applicable.

21. DEPENDENT NAME	INSURANCE COMPANY	POLICY HOLDER DATE OF BIRTH	EFFECTIVE DATE OF POLICY	TERMINATION DATE

DEPENDENTS

List spouse and eligible children to be covered under health and/or dental plan(s). If they are not listed, they will not be covered.

Add (A) or Delete (D)	22. Dependent SSN#	Last Name	First Name	SEX M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Status
	Spouse						Spouse employed by state-covered entity? ☐Yes ☐No
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated

CERTIFICATION & AUTHORIZATION

23. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period (every two years). Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period (every two years) unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan.
AUTHORIZATION: I understand that it is my sole responsibility to pay all required premiums for all plans selected. Failure to pay the required premiums by the due dates will result in cancellation of coverage. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.
DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Enrollee Signature _____ Date _____

COBRA NOTICE OF ELECTION FORM INSTRUCTIONS

ELIGIBILITY: Select one to indicate eligibility if you are enrolling under COBRA for the first time. New COBRA enrollees should also indicate date of occurrence of the qualifying event (i.e., date left employment, disability approved by Social Security, divorce, child ineligible, etc.). If you are already enrolled under COBRA and are making a change, skip to the Action section.

ACTION: If you are enrolling under COBRA for the first time, check "New Subscriber." If you are already enrolled under COBRA and making a change, check "Change" and indicate the type of change and date of occurrence. If you wish to terminate your COBRA coverage, check "Termination."

ENROLLEE INFORMATION: Blocks 1-16 must be completed for all transactions, including terminations. **In block 16**, indicate the county code of your mailing address. If coverage is for dependent children only, enrollee information should be for the youngest child or, if applicable, for a child covered under Medicare; additional children should be indicated as dependents in **block 22**.

LIST OF CODE NUMBERS OF S.C. COUNTIES:

01 Abbeville	11 Cherokee	21 Florence	31 Lee	41 Saluda
02 Aiken	12 Chester	22 Georgetown	32 Lexington	42 Spartanburg
03 Allendale	13 Chesterfield	23 Greenville	33 McCormick	43 Sumter
04 Anderson	14 Clarendon	24 Greenwood	34 Marion	44 Union
05 Bamberg	15 Colleton	25 Hampton	35 Marlboro	45 Williamsburg
06 Barnwell	16 Darlington	26 Horry	36 Newberry	46 York
07 Beaufort	17 Dillon	27 Jasper	37 Oconee	99 Out of S.C.
08 Berkeley	18 Dorchester	28 Kershaw	38 Orangeburg	
09 Calhoun	19 Edgefield	29 Lancaster	39 Pickens	
10 Charleston	20 Fairfield	30 Laurens	40 Richland	

COVERAGE. ALTERATIONS IN THIS SECTION ARE NOT ALLOWED:

In block 17, select one health plan and one level of coverage or check "Refuse All Above Health Plans." Changes from one health plan to another are allowed only during designated enrollment periods (exceptions: changes due to eligibility for Medicare and if HMO enrollee moves out of the service area). The Savings Plan is available only to non-Medicare enrollees and dependents. If you refuse health coverage and enroll under dental, you can enroll yourself and all eligible dependents within 31 days of a special eligibility situation or during the next designated open enrollment period if applicable.

In block 18, indicate level of dental coverage or "Refuse." If you refuse dental coverage and enroll under health you can enroll yourself and all eligible dependents within 31 days of a special eligibility situation or during the next designated open enrollment period, if applicable.

In block 19, indicate Dental Plus ("Yes" to enroll or "Refuse"). You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

MEDICARE AND OTHER COVERAGE: In block 20, list yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

In block 21, if you checked "Yes," list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check "No" and list the termination date of the policy.

DEPENDENTS: In block 22, list spouse and indicate if spouse is a covered employee or retiree of a state-covered entity. List all dependents to be covered under health and/or dental. If they are not listed, they will not be covered. Legal documentation is required for an ex-spouse and all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister or adopted child). For a child age 19 through 24 to be considered eligible for coverage, the dependent must be a full-time student or incapacitated. (Documentation required for both.) Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Read block 23 carefully, sign and date form.

Send the original form to the Employee Insurance Program, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.